New Jersey Department of Health and Senior Services
Division of Aging and Community Services

INSTRUCTIONS FOR COMPLETING THE PLAN OF CARE (WPA-2) FORM

TERMS:

Code:
Code means a unique identifier assigned to each selection in a set of like items, e.g., services, needs, etc. The use of codes enables the capture of distinct hard data amenable to analysis. The following codes are used in the Plan of Care:

1. **Need** codes are used to identify participant problem areas.

   - ADLs identify the specific activity of daily living.

   - IADLs identify the specific instrumental activity of daily living.

2. **Desired goal** code identifies the objective of the service in terms of client functioning in the need area.

3. **Frequency** codes are used to distinguish the number of times a service should occur.

4. **Provider type** codes are used to identify persons who assist a participant in the areas of need.

5. **Payment source** codes are used to identify the source of funding for a service.

6. **Monitoring method** codes are used to identify how service provision may be verified.

7. **Monitoring frequency** codes indicate how often service verification is to be performed.

8. **Unmet need** codes communicate those participant needs not addressed in the current Plan of Care.

9. **Service Needed** may be used to identify distinct services.

10. **Units** refer to the number of units of service required during an occurrence/visit and are also used for billing.

Plan of Care Document Instructions (Side 1):

1.	**Participant Name**	Enter participant's name.
2.	**JACC/Medicaid No.**	Enter Medicaid number or JACC identification number.
3.	**Case Manager Name/No.**	Enter the case manager's name and unique identifying number if applicable.
4.	**Consumer Directed**	Indicate if client is able to use Client Employed Providers (CEP) based on the CAT, client file information, client interview, and CN 461 as necessary, N/A for CCPED & AL/AFC
5.	**Care Plan Date**	Enter Plan of Care Date. This is the date the Plan contents are discussed with the participant. For Assisted Living/AFC this is the date the Plan of Care has the signatures of Participant, Case Manager, Facility, and Case Management Supervisor.

6.	**Re-assessment Date**	Enter the date participant re-assessment is due. This is the month of the initial home visit, 1 year forward. Example: initial home visit was 3/7/00, Re-assessment is 3/01.
7.	**Program**	Indicate program of participant's enrollment.
8.	**Date**	Enter date the problem is identified and written into the Plan of Care.
9.	**Need Code**	Enter need code number from the list at the bottom of the page. For other, specify in item 10. For ADLs and IADLs, use the alpha-numeric combination
10.	**Problem Statement**	Briefly expound on code to indicate reason for need.
11.	**Service Needed**	Enter name of services, and code* if appropriate, required to meet needs or to fill gaps between needs and informal supports. *(JACC/CAP only. List of codes is in manual.)
12.	**Desired Goal Code**	Enter the appropriate goal from the list at the page bottom. Indicate meaning of "other" if used. The Code answers the question of the participant's functioning with regard to the problem. Do we want his level maintained? Do we want to enable independent functioning in the area? Do we want to restore functional ability? Do we want to prevent the problem from recurring? Do we want to resolve the issue, e.g. installation of a ramp resolves lack of egress.
13.	**Units**	Enter units of service needed per visit/occurrence.
14.	**Frequency**	Indicate frequency code of support provided/required.
15.	**Provider Type**	Enter code for type of provider.
16.	**Provider**	Enter name of provider when known.
17.	**Special Requirements**	Enter Y/N comment in item 24 as necessary on any special requirements of Client-Employed providers determined by the case manager, participant, and others providing input to the Care Plan.
18.	**Payment Source**	Enter code for service payment source.
19.	**Monitoring Method**	Enter code for how service delivery can be verified.
20.	**Monitoring Frequency**	Enter minimum monitoring frequency code required for this service.
21.	**Desired Goal Achieved**	Upon review of the Plan of Care or determination that a service is no longer needed, enter Y/N to indicate if the outcome in item 12 was achieved. As needed, comment in item 24 or reference monitoring entry to clarify "N" result.
22.	**Date**	Enter date of entry recorded in item 21. (Put additional dates in the special notes section #24).

Plan of Care Document Instructions: Side 2

23.	**Reason Need Unmet**	Enter the code to indicate why need was unmet and the impact on the individual's health, safety and well being which may require vigilance by the case manager. This section is a component of the Long Term Care Assessment and must be addressed at the reassessment.
24.	**Special Notes or Comments**	Enter any additional comments including the date and initial each entry.

Long Term Care Assessment: Side 2

25. **Case Manager Narrative** Expound on the health and healthcare needs of the participant.

26. **Case Manager Narrative** Expound on the Social Support Network of the participant.

27. **Case Manager Narrative** Expound on the Physical environment of the participant.